Washington State Department of Health
Public Health Laboratories

State of Washington
Department of Health
PUBLIC HEALTH LABORATORIES
1610 N.E. 150th Street
Shoreline, Washington 98155-9701
Phone: (206) 418-5400
Fax: (206) 418-5545
MTS #1327 CLIA #50D0661453
Http://WWW.DOH.WA.GOV/EHSPHL/PHL

SEROLOGY/VIROLOGY/HIV

FOR PHL USE ONLY

Lab Number Date/Time Received

Please Print Clearly

PATIENT

NAME (LAST)

(FIRST) (MI)

ADDRESS

CITY STATE ZIP CODE

MALE ○ FEMALE ○ DATE OF BIRTH MO DAY YR COUNTY

CHART OR PATIENT ID NUMBER

PT PHONE: ( )

PHYSICIAN PHYSICIAN'S PHONE # ( ) -

SUBMITTER

NAME OF PERSON COMPLETING THIS FORM PHONE # ( ) -

MAIL RESULTS TO:

CITY, STATE, ZIP CODE:

COUNTY

AREA CODE & PHONE # ( ) - FAX # ( ) -

THIS SECTION IS REQUIRED

Testing for swine-origin influenza A H1N1 will only be performed if one of the following criteria are met:

☐ Yes ☐ No	Death suspected due to influenza **OR**
☐ Yes ☐ No	Hospitalized patient with positive influenza A test **OR**
☐ Yes ☐ No	Pregnant woman with positive influenza A test **OR**
☐ Yes ☐ No	Healthcare worker with positive influenza A test **OR**
☐Yes ☐ No	Designated sentinel provider for influenza **OR**
☐Yes ☐ No	Designated sentinel laboratory for influenza **OR**
☐Yes ☐ No	Other public health reason approved by local health jurisdiction:

SPECIMEN INFORMATION

ATTENTION: (See Instructions on Reverse Side of Form)

○ SYPHILIS SEROLOGY (X) VIRUS ○ HIV

SPECIFIC AGENT SUSPECTED: **H1N1 (Swine Flu)**

DATE COLLECTED MO DAY YR TIME OF DAY ___:___ ○ AM ○ PM

DATE OF ONSET MO DAY YR TIME OF DAY ___:___ ○ AM ○ PM

DATE SENT TO STATE MO DAY YR FATAL? ○ YES ○ NO

SUBMITTER'S LAB NUMBER:

TYPE OF SPECIMEN

○ SERUM/BLOOD ○ CSF (X) NP/THR ○ ORASURE

○ OTHER (SPECIFY) _____

VIRUS EXAMINATIONS

Chief Clinical Findings. (check system involved and list chiefs symptoms)

(X) Respiratory _____

○ Central Nervous System _____

○ Cutaneous Eruptions- Location and Type _____

○ Other _____

Optimally, collect isolation specimen within 3 days of onset. Submit each specimen as soon as collected. Keep at refigerator temperatures. 24 hour delivery is perferred

SYPHILIS SEROLOGY

Reason For Test

○ **Treatment Control** (VDRL only, Syphilis already confirmed)

○ **Prenatal** (Screen due to pregnancy)

○ **Premarital State** _____ (Required for Marriage LIcense)

○ **Diagnostic/Screen** (VDRL as screen, if reactive TPPA will be performed for confirmation

○ **Reference** (VDRL and TPPA performed, Clinical history indicative of Syphilis)

SYMPTOMS

○ NO ○ YES _____

(If yes, list symptoms. Check REFERENCE)

PREVIOUS TEST RESULT: (Please list any previous test results pertaining to specimen submission)

○ VDRL_____ ○RPR_____ ○OTHER_____

HIV

TYPE OF TEST REQUESTED: ○ ELISA ○ WESTERN BLOT

PREVIOUS HIV TEST DONE? ○ YES ○ NO ○ DON'T KNOW ○ DECLINED

IF YES, TYPE OF TEST DONE: ○ Conventional ○ Rapid ○ Other_____

SAMPLE TYPE: ○ Blood-Finger Stick ○ Blood - Venipuncture ○ Blood Spot ○ Oral Mucosal Transudate ○ Other_____

RESULT: ○ Positive ○ Negative ○ Preliminary Positive ○ Indeterminant ○ Don't Know ○ Declined ○ Not Asked

HAS A PREVIOUS SPECIMEN ON THIS PATIENT BEEN TESTED AT THE STATE LAB?

○ YES ○ NO STATE LAB NUMBER _____

FOR PHL USE ONLY

Date/Time Reported: